STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155200		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/20/2012			
	OVIDER OR SUPPLIER		B. WIN	STREET A 1564 S	ADDRESS, CITY, STATE, ZIP CODE UNIVERSITY BLVD D, IN 46989	<u> </u>	
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	1	ID			(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	HOULD BE COMPLE	
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
TAG F0000	This visit was for State Licensurer Survey dates: April 16, 17, 18 Facility number Provider number AIM number: 10 Survey team: Delinda Easterl Betty Retherfor Ginger McNam Karen Lewis RN Census bed typ SNF/NF: 56 Total: 56 Census payor to Medicare: 9 Medicaid: 40 Other: 7 Total: 56 These deficience findings cited in IAC 16.2.	or a Recertification and e Survey. 19, 20, 2012 200107 20: 155200 20290330 y RN TC d RN ee RN N	F00	TAG	CROSS-REFERENCED TO THE APPROPRIA	s n cited	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SU	RVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	л ріш	LDING	00	COMPLET	ED
		155200	A. BUII B. WIN			04/20/20	012
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				UNIVERSITY BLVD		
UNIVERS	SITY NURSING CE	NTER		UPLAND, IN 46989			
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE (COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0253 SS=E	SERVICES The facility must maintenance ser a sanitary, order Based on obse the facility faile	g & MAINTENANCE provide housekeeping and vices necessary to maintain ly, and comfortable interior. rvation and interview, d to ensure resident e well maintained and	F02	53	F 253 Housekeeping and Maintenance Services Wha corrective action(s) will be	t	05/20/2012
	in good repair f bathrooms obs 101, 103, 104, 110,111, 112, had the potenti	or 11 of 35 resident erved. (Room numbers 106, 108, 109, 205 and 207) This			accomplished for those reside found to have been affected be the deficient practice: Roc identified in the survey have be repaired including the walls ar wallpaper, the floor tiles have been cleaned and the grout repaired, the doors and door frames were repaired and pair as needed. How other	y oms een nd	
	Maintenance D Housekeeping	ronmental tour with the irector and the Supervisor on 4/19/12 e following concerns			residents having the potential be affected by the same defici practice will be identified and what corrective action(s) will b taken: · All residents have potential to be affected by this deficient practice. · All Department Managers have b assigned a section of resident rooms to monitor on a weekly	ent the een	
	sections of wall and peeling aw bathroom had 3 that were stained bathroom wall white patching B. The bathroot sections of wall	m in room 101 had paper that was loose ay from the wall. The sections of floor tiles and discolored. The had 3 areas of dried material on the wall. m in room 103 had paper that was loose ay from the wall. The			basis. Findings from these roor rounds will be documented on Customer Care Room Rounds checklist. Items identified on the form as needing correction or repair will be forwarded to the Department Manager and the Executive Director for follow-uhor The Executive Director will monitor that the corrections has been made or if delayed an explanation will be given to the resident and/or responsible pages.	om the sthe	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **765W11**

Facility ID: 000107

If continuation sheet Page 2 of 49

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	л ріш	LDING	00	COMPLETED
		155200	B. WIN			04/20/2012
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIEF	₹			UNIVERSITY BLVD	
LINII\/EDG	SITY NURSING CE	NITED			D, IN 46989	
UNIVERS	SITT NURSING CE	INTER		UFLAN	D, IN 40909	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	bathroom floor	had 5 tiles around the			What measures will be put in	l l
base of the stool that had					place or what systemic change	
	approximately	a 1/4 inch gap between			will be made to ensure that the	
		gap in the tiles exposed			deficient practice does not rec	ur:
	bare wood floo				 All Department Managers have been assigned a section 	of
	Baic wood noo	inig.			resident rooms to monitor on a	l l
	C. The bathroom in room 104 had 3				weekly basis. Findings from	
					these room rounds will be	
	· ·	s of floor tiles which			documented on the Customer	
		nd discolored. The			Care Room Rounds checklist.	
	bathroom metal door frames were				Items identified on the form as	
	gouged and had sections of paint				needing correction or repair w	l l
	missing from the frames.				be forwarded to the Departme	nt
					Manager and the Executive	
	D. The metal d	oor frames in			Director for follow-up. • The Executive Director will monitor	
					that the corrections have been	
		were gouged and had			made or if delayed an explana	
	•	nt missing from the			will be given to the resident	don
	frames.				and/or responsible party. · Th	ne
					Executive Director inserviced	l l
	E. The bathroo	m in room 108 had 3			Department Managers on the	
	floor tile square	es which were stained			Customer Care Room Rounds	;
	and discolored				program and checklist. This	
					checklist will be used to identif	·y
	F The hathron	m door to room 109			any resident care, and	
					environmental or maintenance	
		ack scuff marks on the			issues in the resident rooms a bathrooms. How the	nu
		or. The bathroom			corrective action(s) will be	
		nes were gouged and			monitored to ensure the deficient	ent
	had sections of	f paint missing from the			practice will not recur; i.e. wha	
	frames.				quality assurance program wil	
					put into place: Executive	
	G. The wooder	n entrance door to the			Director/Designee will be	
		om 110 had 4 small			responsible for monitoring the	
		or. The wooden door			checklists on a weekly basis for	l l
		here the door was			weeks, monthly for 3 months a	and
					quarterly thereafter.	
	scratched and	marred.			Corrections identified on the Customer Care Room Rounds	
					Customer Care Room Rounds	

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155200	(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 00	(X3) DATE COMPI 04/20	LETED
		100200	B. WING	ADDRESS SITE OF THE SOL		12012
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD UNIVERSITY BLVD	E	
UNIVERS	SITY NURSING CE	NTER		ID, IN 46989		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	LD BE	(X5) COMPLETION DATE
TAG	H. The bathroosections of white material over so bathroom wall to observed in the bathroom wall is caulk around the cracked dry and was missing. I. The bathroom sections of wall away from the sections of wall away from the sections of floorections of fl	m in room 111 had te dried patching everal areas of the 4 small holes were e drywall in the near the sink. The ne bathroom sink was d sections of the caulk in in room 112 had lipaper that was peeling wall. athroom door frame in gouged and had paint ne frame. m in room 207 had 3 r tiles which were discolored.	TAG	checklist tool will be discu the monthly CQI Meeting plan adjusted accordingly what date the systemic cl	and the v. By hanges ystemic	DATE

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **765W11**

Facility ID: 000107

If continuation sheet

Page 4 of 49

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPL	ETED
		155200	B. WIN			04/20/	2012
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	L			UNIVERSITY BLVD		
UNIVERS	SITY NURSING CE	NTER	UPLAND, IN 46989				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0323 SS=D	483.25(h) FREE OF ACCID HAZARDS/SUPI The facility must environment rem hazards as is po receives adequa assistance devic A.) Based on c review, and inte failed to ensure a secured unit non secured ur without an asse interventions in elopement, for reviewed for ele residents residi unit. (Resident B.) Based on c review, and inte failed to ensure functioning call summon staff for prevent possibl residents obser call light system #60) Findings includ A1.) The clinic #38 was review	ensure that the resident hains as free of accident ssible; and each resident te supervision and less to prevent accidents. Observation, record erview, the facility a resident residing on was not moved to a nit for an overnight visit essment for safety and place to prevent 1 of 1 resident opement of 18 ing on the secured #38) Observation, record erview, the facility each resident had a light in place to or assistance to be falls, for 2 of 40 rved for a functional m. (Resident #58 and	F03	23	F 323 Free of Accident Hazards/Supervision/Devices What corrective action(s) will be accomplished for those reside found to have been affected by the deficient practice: A1) residents residing in the locked unit were reassessed for wandering. Those residents found to be at risk for wandering were given a Wander Guard alarm. Resident #38 was give an alarm. B1) A new call lig system will be installed on the locked unit by 05/20/12. The reall light system will be installed all resident rooms including Room 210 where Residents 52 and 60 reside, the bathrooms shower room. How other residents having the potential be affected by the same defici practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected by the deficient practice. A1) All residents residing in the locked unit were reassessed for wandering. Those residents found to be at risk for wandering were given a Wander Guard	nts y All d ng ht new ed in 8 and to ent e	05/20/2012
	summon staff for prevent possible residents observed (all light system #60) Findings include (A1.) The clinic	or assistance to le falls, for 2 of 40 rved for a functional n. (Resident #58 and e: al record for Resident			shower room. How other residents having the potential be affected by the same defici practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected by the deficient practice. A1) All residents residing in the locked unit were reassessed for wandering. Those residents found to be at risk for wanderial.	to ent e ne	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **765W11**

Facility ID: 000107

If continuation sheet

Page 5 of 49

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DDIC	00	COMPL	ETED
		155200	A. BUII B. WIN			04/20/	2012
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			UNIVERSITY BLVD		
LINII\/ED	SITY NURSING CE	NTED			D, IN 46989		
UNIVER	SITT NURSING CE	NIER		UPLAN	D, IN 46989		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Diagnoses for	Resident #38 included,			rooms including Room 210, th	е	
	but were not lir	nited to, debility,			bathrooms and shower rooms	••	
	abnormal gait, multiple falls,				and common areas in the facil have been checked for	ity	
	unspecified mental retardation,				functioning call lights. Any cal	ı	
	disturbance conduct, depression,				lights not working properly have		
					been repaired or replaced. W		
	Parkinson's disease, Alzheimer's				measures will be put into place		
	dementia, and anxiety.				what systemic changes will be		
	The eliminal res	and indicated Decident			made to ensure that the deficie		
	The clinical record indicated Resident				practice does not recur: · All		
	#38 had resided on an alarmed				staff was inserviced by the	2	
	secure unit since his readmission to				Executive Director on 05/08/12 the call light system, the	2 on	
	the facility on 10/26/11 following a				procedure for when a call light	is	
	hospitalization	for behavioral issues.			not working properly, proper	10	
	The resident ha	ad previously resided			documentation, and the tools		
	on a non secur	ed unit with his wife			used to monitor the deficiency	. •	
	prior to hospita	lization for aggressive			A1) DNS/ADNS inserviced the		
		ards his wife on			licensed nurses 05/10/12 on the		
		previous bed in his			Wander Guard system, testing	l	
		nained unused.			the alarms on each shift,	tha	
	Wile 3 100111 Tell	named undsed.			documenting in the TAR's and procedure is an alarm is not	uie	
	Duning a see also				working properly. Resident		
		ervation on 4/17/12 at			alarms will be checked each s	hift	
	•	sident #38 was			by the charge nurse to ensure		
		ambulating in hall on			they are operating correctly.		
	the secured un	it with his walker			Monitoring of the alarms will be	е	
	without assista	nce from the staff.			documented in Treatment		
					Administration Records [TAR].		
	A "Continuum o	of Care Plan" from the			Any alarms found not working	,	
		ioral unit, dated			properly will be replaced with a new unit that has been tested		
		ated "Patient needs a			the charge nurse. · B1)	~ y	
		nd highly supervised			DNS/ADNS inserviced the		
		insure the safety of			licensed nurses and CNA's on	the	
		•			call light system, ensuring they	/	
	the patient and	outers.			are in place and operational,		
					documentation and the proced	lure	
	•	olan problem, dated			to follow if one is not working		
	2/24/12, indica	ted Resident #38 had a	1		properly. · All call lights in the	•	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIW DD	10	00	COMPL	ETED
		155200	A. BUILDIN	υG		04/20/	2012
			B. WING	TDEET A	DDDESS CITY STATE ZID CODE		
NAME OF F	PROVIDER OR SUPPLIE	R			DDRESS, CITY, STATE, ZIP CODE		
		NITED			JNIVERSITY BLVD		
UNIVERS	SITY NURSING CE	INTER		PLANL	D, IN 46989		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	Ι	D	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL	PRE	EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	T.	AG	DEFICIENCY)		DATE
ı	need for place	ment on the secured			facility will be checked on a		
	unit due to a history of wandering and				weekly basis by the maintenar	nce	
	stating he was	going to "walk out of			man and documented on his		
	1	are not looking." The			weekly Preventative Maintena checklist. How the corrective		
	1	in indicated the			action(s) will be monitored to	E	
	l	reside on the secured			ensure the deficient practice w	rill	
					not recur; i.e. what quality		
		vould verify the			assurance program will be put		
	resident's locat	tion frequently.			into place: A1) DNS/Desig		
					will monitor the TAR's on a dai		
	A nursing note	entry, dated 2/9/12 at			basis for 4 weeks, weekly for 4	ļ	
	7 p.m., indicated "Res [resident] down				weeks, and then monthly		
	in room [number of wife's room]				thereafter for a minimum of 6		
		pend the night with			months. Any discrepancies wi		
		I was not part of the			be corrected and logged on the CQI Resident Wander Guard	Е	
	secured unit.	. Was not part of the			Monitoring tool. · Weekend		
	Secured unit.				Manager/Designee will ensure		
	The analysis of as a	and lades describe			that the alarms are being teste		
		cord lacked any			on the weekends and report a		
		the resident or other			concerns to the Executive		
	interventions p	ut in place to maintain			Director. · B1) Executive		
	his safety relat	ed to being off of the			Director/Designee will monitor		
	secured unit ov	vernight.			CQI Preventative Maintenance		
					checklist for call lights weekly		
	During an inter	view with the			4 weeks, then monthly thereaf for a minimum of 6 months. A		
		Social Service Director,			discrepancies found on the	ııy	
		f Nursing on 4/18/12 at			checklist will be verified that th	е	
		•			call light has been repaired an		
	•	itional information was			documented on the CQI Resid		
		ted to the supervision,			Call Light Monitoring tool by th		
	1	urity of the resident			Executive Director. · All items		
	1	d overnight with his			identified on the CQI Resident		
	wife on a non s	secured unit.			Wander Guard Monitoring tool		
					and the CQI Resident Call Light		
	During an inter	view with the			Monitoring tool will be discussed at the monthly CQI Meeting an		
	_	on 4/19/12 at 8:25 a.m.,			the plan adjusted accordingly.	iu	
		she had talked to some			The CQI Monitoring tools will be	e e	
					reviewed at the monthly CQI		
	or the nursing s	staff who had worked			Terror at all monding out		

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	IULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	ILDING	00	COMPL	
		155200	B. WIN			04/20/	2012
NAME OF E	PROVIDER OR SUPPLIE	R	_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
TVANIL OF I	ROVIDER OR SOLVER				UNIVERSITY BLVD		
UNIVERS	SITY NURSING CE	ENTER		UPLAN	D, IN 46989		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	†	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		cured unit on the night			meetings for a minimum of six		
		indicated a CNA had			months. By what date the systemic changes will be		
		as aware of his being			completed: Systemic change		
		not remember any			will be completed by 05/20/12		
	· ·	ed to the night in					
	l .	Administrator indicated					
		t of his safety to be off					
		unit had been done.					
		no system had been					
	put in place to	ensure the resident did					
	not attempt to	elope the building or to					
	ensure he was	s supervised while off of					
	the alarmed se	ecure unit.					
	B1.) The clinic	cal record for Resident					
	#58 was reviev	wed on 4/19/12 at 8:45					
	a.m.						
	Diagnoses for	the resident included,					
	but were not lii	mited to, insomnia,					
	encephalopath	ny, history of seizures,					
		rebellum hemisphere,					
		g syndrome. The					
	clinical record	indicated the resident					
	was able to an	nbulate independently.					
	A "Fall Risk As	ssessment", dated					
	3/1/12, indicate	ed Resident #58 was at					
	risk for falls du	e to a seizure disorder,					
	history of falls,	and narcotic,					
	antipsychotic,	and hypnotic					
	medication use	е.					
	A health care p	olan problem, dated					
	3/5/12, indicate	ed Resident #58 was at					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **765W11**

Facility ID: 000107

If continuation sheet Page 8 of 49

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/23/2012 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155200	B. WIN	G		04/20/	2012
NAME OF E	PROVIDER OR SUPPLIEF		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
WINE OF I	KO VIDEK OK SOI I EIEI			1564 S	UNIVERSITY BLVD		
UNIVERS	SITY NURSING CE	NTER		UPLANI	D, IN 46989		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		e to a history of falls,					
		ires, medication use,					
		agnoses. One of the					
		this problem was for					
		have a "call light in					
	reach."						
	During an interview on 4/16/12 at 11:00 a.m., Resident #58 indicated						
		ve a call light in her					
	room. She indicated she had not had						
	_	e she was admitted in					
	1	e indicated she did not					
		nt and would get up					
		nto the hall if she					
		ning. She indicated					
		been given a bell or					
	1	ce to use to summon					
	the staff if need	ded.					
	During on aboa	anistian an A/AC/AO at					
	_	ervation on 4/16/12 at					
		ere was no call light					
		t in the resident's room.					
		n the wall for the call					
		ad a coverplate over the					
		a. The call light in the					
		also noted to be not					
	working.						
	During an inter	view on 4/16/12 of					
	_	view on 4/16/12 at IA #6 indicated					
	1	room used to be used					
	I	oom, and it did not					
	i nave a call ligh	t system in place.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **765W11**

Facility ID: 000107

If continuation sheet Page 9 of 49

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155200	B. WING		04/20/2012
NAME OF F	PROVIDER OR SUPPLIEI	R	STREET	ADDRESS, CITY, STATE, ZIP CODE	
				UNIVERSITY BLVD	
UNIVERS	SITY NURSING CE	INTER	UPLAN	ID, IN 46989	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX	``	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP	RIATE
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	During an inter				
	Administrator and Maintenance Supervisor on 4/16/12 at 11:40 a.m.,				
	additional information was requested related to there being not call light in				
	Resident #58's room.				
	During an obse	envation of Pecident			
		ervation of Resident h the Administrator and			
		Supervisor on 4/16/12			
		they indicated there			
		light system in the			
		n and the bathroom call			
		not working. The			
	•	ndicated Resident #58			
		call light in the room			
		ot know how this			
		een missed. She			
	•	s would be taken to			
	1	blem and both			
		e room would be given			
		til the call light was			
	replaced.				
	B2.) The clinic	cal record for Resident			
	l '	wed on 4/19/12 at 9:30			
	a.m.				
	The clinical red	cord indicated Resident			
	#60 had move	d into her current room			
	on 3/2/12. The	e clinical record			
	indicated the re	esident was able to			
	ambulate inde	pendently.			
		•			
	Diagnoses for	the resident included,			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **765W11**

Facility ID: 000107

If continuation sheet

Page 10 of 49

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155200	B. WING		04/20/2012
NAME OF F	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE	
				UNIVERSITY BLVD	
UNIVERS	SITY NURSING CE	:NIER	UPLAN	D, IN 46989	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	
PREFIX TAG	· ·	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	
IAG		mited to, dementia,	IAG		DATE
		story of falls, syncope,			
	· •	I hypertension.			
	giadooma, ame	Tryperterioion.			
	A "Fall Risk As	ssessment", dated			
	2/8/12, indicated Resident #60 was at				
	· ·	e to a history of falls,			
		at times, confusion at			
	times, and use of assuasive devises.				
	A health care p	olan problem, dated			
	2/17/12, indicated Resident #60 was				
	at risk for falls	due to a history of falls,			
	glaucoma, me	dication use, and			
	syncope. One	of the approaches for			
	this problem w	as for the resident to			
	have "persona	al items in reach			
	including call li	ght."			
		view on 4/16/12 at			
	· ·	esident #60 indicated			
		ve a call light in her			
		licated she would "yell"			
		something. She			
		nad never been given a			
		er device to use to			
	summon the st	taff if needed.			
	District of the second				
	_	ervation on 4/16/12 at			
		ere was no call light			
		t in the resident's room.			
		n the wall for the call			
		ad a coverplate over the			
		ea. The call light in the			
	bathroom was	also noted to be not			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **765W11**

Facility ID: 000107

If continuation sheet

Page 11 of 49

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(2) MUL	TIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN OF CORRECTION IDENTIFICAT	TION NUMBER:	. BUILDI	ING	00	COMPL	ETED
155200	В.	. WING			04/20/	2012
NAME OF BROWNER OF GUIDNIER		5	STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER		·	1564 S เ	UNIVERSITY BLVD		
UNIVERSITY NURSING CENTER		U	UPLANE	D, IN 46989		
(X4) ID SUMMARY STATEMENT O			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX (EACH DEFICIENCY MUST BE			REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OF THE APPROPRIATE	Έ	COMPLETION
TAG REGULATORY OR LSC IDENTIF	YING INFORMATION)	1	TAG	DEFICIENCY)		DATE
working.						
During an interview on 4						
11:35 a.m., CNA #6 indi	cated					
Resident #60's room use	ed to be used					
as a activity room and it	did not have					
a call light system in place						
a samingini system in pier						
During an interview with	the					
Administrator and Mainte						
Supervisor on 4/16/12 at						
additional information wa	•					
related to there being no	t call light in					
Resident #60's room.						
During an observation of						
#60's room with the Adm	ninistrator and					
Maintenance Supervisor	on 4/16/12					
at 11:40 a.m., they indicate	ated there					
was not a call light syste	m in the					
residents room and the b	oathroom call					
light was also not workin	g. The					
administrator indicated F	~					
should have a call light in						
and she did not know ho						
problem had been misse						
indicated steps would be						
correct this problem and						
residents in the room wo	·					
bells to use until the call	light was					
replaced.						
B3.) A review of the cur	rent facility					
policy, dated 9/05, provid	*					
Director of Nursing on 4/	•					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **765W11**

Facility ID: 000107

If continuation sheet Page 12 of 49

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/23/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE COMPL		
		155200	A. BUI B. WIN	LDING IG		04/20/	2012
NAME OF E	PROVIDER OR SUPPLIER	,	P. W.		ADDRESS, CITY, STATE, ZIP CODE		
					UNIVERSITY BLVD		
	SITY NURSING CE			UPLANI	D, IN 46989		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRI		DATE
	a.m., titled "Ca	Il Light Procedure"					
	included, but w	as not limited to, the					
	following:						
	"Durnoss: To	allow regident to					
	"Purpose: To allow resident to request assistance when needed.						
	1040031 0331310	ande when needed.					
	Equipment:						
	1. Functioning	call light.					
		J					
	Procedure:						
	Place call light within reach of						
	resident at all t	imes"					
	3.1-45(a)(2)						
	- (-)()						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **765W11**

Facility ID: 000107

If continuation sheet Page 13 of 49

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION 00	(X3) DATE S	
		155200		LDING		04/20/	2012
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	L	
NAME OF P	ROVIDER OR SUPPLIER				UNIVERSITY BLVD		
UNIVERS	SITY NURSING CE	NTER			ID, IN 46989		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0327 SS=D	HYDRATION The facility must	UID TO MAINTAIN provide each resident with take to maintain proper ealth.					
	Based on obse and interview, to offer fluids of the between meals interviewed for between meals. Findings include Resident #5's or reviewed on 4/ resident's diagrawere not limited debility, anxiety dementia, and The resident has Significant Chasses smer indicated the resident #5 has Care Plan Control The resident has for altered nutripossible medicincreased nutri	che facility failed to be resident's choice in a for 1 of 21 residents being offered fluids at [Resident #5] e: clinical record was 18/12 at 9:21 a.m. The hoses included, but do, corneal dystrophy, and depression, personality disorder. and a 2/29/12, ange Minimum Data at. The assessment esident was cognitively and an Interdisciplinary ference on 2/22/12. The data are problem of at risk attor/hydration due to all causes and/or eent requirements. This	F03	27	F 327 Sufficient Fluid to Main Hydration What corrective action(s) will be accomplished those residents found to have been affected by the deficient practice: Resident #5 is provided with lemonade between als. How other residents having the potential to be affected by the same deficient practice be identified and what correcting action(s) will be taken: All alert and oriented residents including Resident #5 will be interviewed regarding their preferences for in-between menty hydration using the Dietary Resident Interview form. The plan of care for potentially affected residents including Resident #5 have been updated to include the residents' preferences for in-between meal hydration. The plan of care for potentially affected residents including Resident #5 have been review and updated as indicated. What measures will be put interviewed one on the control of the process of the plan	een cted will ive lave ches ees eecur:	05/20/2012
	problem had ar preferences.	n approach to provide			interviewing residents and completing the Dietary Reside	ent	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	URVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLE	ETED
		155200	B. WIN			04/20/2	2012
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R			UNIVERSITY BLVD		
UNIVER	SITY NURSING CE	ENTER			D, IN 46989		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID		I	(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
IAG	During an inte on 4/16/12 at 3 indicated she refused to have She indicated and her daugh stocked in her she would like between mealmot able to get indicated she give her some always in a hud don't offer her water she decended buring an inte 3:00 p.m., with Nursing, she in aware of the relemonade duri indicated she and put it on the sheets. During an inte 2:55 p.m., with the resident of the indicated the rindicated the rin	rview with the resident 3:05 p.m., Resident #5 did not drink water and e it kept in her room. she prefers lemonade ter keeps lemonade closet. She indicated to have a glass of it s. She indicated she is it for herself. She doesn't ask the staff to because they are rry. She indicated they anything except the		IAU	Interview form on admission, readmission, quarterly, annual and with significant changes to obtain resident preference for in-between meal hydration. DNS/Designee will educate the nursing staff on 05/10/12 on the residents' preferences for in-between meal hydration. DNS/Designee will update CN assignment sheets with reside preferences for in-between meal hydration. The Interdiscipling Care Plan team will review and update the residents' care plan as needed. How the correct action(s) will be monitored to ensure the deficient practice who to recur; i.e. what quality assurance program will be put into place: DSN/Designee be responsible for ensuring residents hydration preference are being honored by using the Hydration Preference CQI toodomly monitor all three shift weekly x 4 weeks, then month for a minimum of six months. The Hydration Preference CQ Monitoring tool will be reviewed the monthly CQI meeting and plan will be adjusted as needed By what date the systemic changes will be completed: Systemic changes will be completed: Systemic changes will be completed.	e e e e A A A A A A A A A A A A A A A A	DATE

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/23/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION IDENTIFICATION NUMBER: 155200	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 04/20/2012
	PROVIDER OR SUPPLIER SITY NURSING CENTER	1564 S	ADDRESS, CITY, STATE, ZIP CODE UNIVERSITY BLVD D, IN 46989	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE COMPLETION
	resident if she would like some lemonade.			
	Revised 3/08, "Hydration Management Program" was provided by the Director of Nursing on 4/20/12 at 8:40 a.m. The purpose of the program was to ensure all residents receive appropriate interventions to support adequate hydration each day unless otherwise directed by a physician or indicated by advance directives. The program indicated the resident will be included in assessing, planning, and intervention of controlling or eliminating risk, including providing for resident preferences on the plan of care. 3.1-46(b)			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **765W11**

Facility ID: 000107

If continuation sheet

Page 16 of 49

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MI	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155200	B. WIN		·	04/20/	2012
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				UNIVERSITY BLVD		
UNIVERS	SITY NURSING CE	NTER			D, IN 46989		
			1	ID	,		(V.5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	DATE
		LSC IDENTIFTING INFORMATION)		TAG	BELLEENery		DATE
F0356	483.30(e) POSTED NURS	E STAFFING					
SS=C	INFORMATION	ESTAFFING					
	The facility must post the following						
	information on a						
	o Facility name.	aan, basis.					
	o The current da	te.					
	o The total numb	per and the actual hours					
		llowing categories of					
		icensed nursing staff directly					
		esident care per shift:					
	- Registered						
		ractical nurses or licensed					
		s (as defined under State					
	law). - Certified nu	ree aides					
	o Resident censi						
	o resident cense						
	The facility must	post the nurse staffing data					
		on a daily basis at the					
		h shift. Data must be posted					
	as follows:						
	o Clear and read						
	•	place readily accessible to					
	residents and vis	sitors.					
	The facility must	, upon oral or written request,					
		ing data available to the					
		at a cost not to exceed the					
	community stand						
	•						
	The facility must	maintain the posted daily					
		ta for a minimum of 18					
		quired by State law,					
	whichever is great						0.7/20/202
	Based on obse	rvation, record review	F03	56	F 356 Posted Nurse Staffing		05/20/2012
	and interview, t	he facility failed to			Information What corrective		
	ensure the list	of nursing staff on			action(s) will be accomplished	tor	
		d and updated on a			those residents found to have been affected by the deficient		
		equired. This had the			practice: · Nurse staffing		
	_	•				d	
	potential to effe	ect 56 residents who			information will be updated and	d	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **765W11**

Facility ID: 000107

If continuation sheet Page 17 of 49

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		DDIG	00	COMPL	ETED
		155200	A. BUIL			04/20/	2012
			B. WING		DDDESS CITY STATE ZID CODE		
NAME OF I	PROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP CODE		
LINID (ED)		NTED			UNIVERSITY BLVD		
UNIVER	SITY NURSING CE	NIER		UPLAN	D, IN 46989		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	resided in the f	acility.			posted daily in a clear readable	е	
		,			format in a prominent place		
	Findings includ	۵:			readily accessible to residents	;	
		C.			and visitors How other		
					residents having the potential		
	_	al tour of the facility on			be affected by the same defici	ent	
	4/16/12 at 8:50 a.m. the nursing staff				practice will be identified and		
	on duty posting	was observed on the			what corrective action(s) will be		
	wall outside of	the therapy			taken: · All residents have potential to be affected by this		
		he posting was dated			practice. Nurse staffing	•	
	4/13/12.	. 3			information will be posted dail	v bv	
	.,				the night shift charge nurse in		
	During on inter	vious with Nursing Stoff			clear and readable format in a		
		view with Nursing Staff			prominent place readily		
		at 9:00 a.m., she			accessible to residents and		
	indicated the lis	st of nursing staff on			visitors. What measures wil	l be	
	duty was to be	updated daily at the			put into place or what systemi		
	beginning of ea	ach shift. She further			changes will be made to ensu		
	indicated the p	osted list of staff on			that the deficient practice does		
		lity was dated 4/13/12.			not recur: · DNS/Designee		
	1	he list of staff should			have educated the night shift		
					charge nurses on posting the nurse staffing information dail		
	have been upd	aleu.			Weekend Manager will ensure		
	l <u></u>				the nurse staffing information		
	3.1-17(a)				posted on the weekends and		
					document on the Weekend		
					Managers Report. How the		
					corrective action(s) will be		
					monitored to ensure the defici		
					practice will not recur; i.e. wha		
					quality assurance program wil	l be	
					put into place: • Executive		
					Director/Designee will be responsible for monitoring the		
					daily posting of the nurse staff		
					information on the Posted Nur		
					Staffing CQI tool. Results o		
					the Posted Nurse Staffing CQ		
					tool will be discussed monthly		
					the CQI meeting for three mor		
							l

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **765W11**

Facility ID: 000107

If continuation sheet

Page 18 of 49

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/23/2012 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155200	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 04/20/2012	
NAME OF P	PROVIDER OR SUPPLIER	<u> </u>	STREET .	ADDRESS, CITY, STATE, ZIP CODE	3	
UNIVERS	SITY NURSING CE	NTER		UNIVERSITY BLVD ID, IN 46989		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	OPRIATE (X5) (X5) COMPLETION DATE	
				and then quarterly there a The plan adjusted as need By what date the systemic changes will be completed Systemic changes will be completed by 05/20/12.	fter. ded.	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **765W11**

Facility ID: 000107

If continuation sheet

Page 19 of 49

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155200	B. WIN			04/20/	2012
	PROVIDER OR SUPPLIER		•	1564 S	ADDRESS, CITY, STATE, ZIP CODE UNIVERSITY BLVD D, IN 46989		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	E	DATE
F0371 SS=E	483.35(i) FOOD PROCUE STORE/PREPAI The facility must (1) Procure food considered satis local authorities; (2) Store, prepar under sanitary or Based on obse the facility failer on room trays or being transport to the resident carts observed potential to affe who had meal of food cart. Findings includ 1.) During an or Hall on 4/16/12 staff members passing food tra residents who or rooms. The die in the television took the trays of television loung down the hallw rooms. Three or had open, uncounted them. Each tra coleslaw and p	RE, RE/SERVE - SANITARY - from sources approved or factory by Federal, State or and e, distribute and serve food onditions rvation and interview, d to ensure all items were covered while ed from the food cart rooms for 1 of 2 food . This had the ect 33 of 33 residents trays delivered on a e: observation on the 300 e at 11:55 a.m., two	F03	71	F 371 Food Procure, Store/Prepare/Serve - Sanitary What corrective action(s) will be accomplished for those reside found to have been affected by the deficient practice: Diet Manager inserviced the dietary staff on 05/08/12 on the prope procedure of distributing and serving food trays under sanital conditions. All food and beverages will be properly covered while being transporte from the food cart to the reside rooms. How other residents having the potential to be affect by the same deficient practice be identified and what correcting action(s) will be taken: All residents have the potential to affected by the deficient practice. Dietary Manager inserviced dietary staff on 05/08/12 on the proper procedure of distributing and serving food trays under sanitary conditions. The Executive Director inserviced a staff on 05/08/12 on the policy that all food being transported the residents' room and the Auguste's Cottage Dining Room must be properly covered. A food and beverages will be	ee ints / r r ary ed ent cted will ve be ce. the eg g all to m	05/20/2012

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **765W11**

Facility ID: 000107

If continuation sheet

Page 20 of 49

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/23/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155200		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 04/20/2012	
	PROVIDER OR SUPPLIER		STREET	ADDRESS, CITY, STATE, ZIP CODE UNIVERSITY BLVD ID, IN 46989	ı
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE COMPLETION
	#1 on 4/20/12 a indicated that 1 for breakfast, 1	view with kitchen cook at 10:15 a.m., she 2 hall trays are served 0 hall trays are served 11 hall trays are served		properly covered while bein transported from the food of the resident rooms. What measures will be put into ple what systemic changes will made to ensure that the depractice does not recur: Dietary Manager inserviced dietary staff on 05/08/12 on proper procedure of distributional serving food trays undestantary conditions. All for and beverages will be proposed while being transported while being transported to the restrooms. How the corrective action(s) will be monitored the ensure the deficient practice not recur; i.e. what quality assurance program will be into place: Dietary Manager/Designee will more the trays before they leave kitchen. Trays will be monitored the trays before they leave kitchen. Trays will be monitate each meal to ensure food beverages are properly covat each including weekends weeks then monthly for a minimum of 6 months. Monitoring will be document the CQI Dietary Tray Monitoring tool will be reviet the monthly CQI Meeting and plan will be adjusted according the CQI Meeting and plan will be adjusted according the CQI Meeting and plan will be adjusted according the CQI Meeting and plan will be adjusted according tool will be reviet the monthly CQI Meeting and plan will be adjusted according the CQI Meeting and plan will be adjusted according tool will be revieted at the CQI Meeting and plan will be adjusted according tool will be completed. Systemic changes will be completed to 5/20/12.	art to t ace or be ficient the the the tring er od erly orted sident ee o e will out nitor the tored d and ered d for 4 ted on oring ey wed at nd the lingly. Il be g for a y what will be

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **765W11**

Facility ID: 000107

If continuation sheet Page 21 of 49

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/23/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155200			LDING	00	(X3) DATE S COMPL 04/20 /	ETED	
	PROVIDER OR SUPPLIER		<u> </u>	1564 S	ADDRESS, CITY, STATE, ZIP CODE UNIVERSITY BLVD D, IN 46989		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	at 7:50 a.m. The being passed of	observation on 4/18/12 the hall trays were on the 100 hall. The ere not covered.	F03	71	F 371 Food Procure, Store/Prepare/Serve - Sanitary What corrective action(s) will be accomplished for those reside found to have been affected be the deficient practice: Manager inserviced the dietary staff on 05/08/12 on the proper procedure of distributing and serving food trays under sanitate conditions. All food and beverages will be properly covered while being transported from the food cart to the residence be identified and what correcting action(s) will be taken: All residents have the potential to affected by the deficient practice be identified and what correcting action(s) will be taken: Dietary Manager inserviced dietary staff on 05/08/12 on the proper procedure of distributing and serving food trays under sanitary conditions. The Executive Director inserviced staff on 05/08/12 on the policy that all food being transported the residents' room and the Auguste's Cottage Dining Room must be properly covered. Auguste's Cottage Dining Room must be properly covered while being transported from the food cart the resident rooms. What measures will be put into place what systemic changes will be made to ensure that the deficient practice does not recur: Dietary Manager inserviced the dietary staff on 05/08/12 on the dietary st	oe onts y ttary y r ary ed ent cted will ve be ce. the e g all to m All to e or ent e	05/20/2012

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **765W11**

Facility ID: 000107

If continuation sheet

Page 22 of 49

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/23/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN	OF CORRECTION IDENTIFICATION NUMBER: 155200 A. BUILDING B. WING			COMPLETED - 04/20/2012	
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
UNIVERS	SITY NURSING CEI	NTER		UNIVERSITY BLVD D, IN 46989	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				proper procedure of distributing and serving food trays under sanitary conditions. All food and beverages will be properly covered while being transported from the food cart to the reside rooms. How the corrective action(s) will be monitored to ensure the deficient practice who trecur; i.e. what quality assurance program will be put into place: Dietary Manager/Designee will monitor the trays before they leave the kitchen. Trays will be monitored to each meal to ensure food a beverages are properly covered at each including weekends for weeks then monthly for a minimum of 6 months. Monitoring will be documented the CQI Dietary Tray Monitoring tool will be reviewed the monthly CQI Meeting and plan will be adjusted according This CQI Monitoring tool will be reviewed at the CQI Meeting finimum of 6 months. By we date the systemic changes will completed: Systemic changes will completed by 05/20/12.	/ ed ent // ed ed

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **765W11**

Facility ID: 000107

If continuation sheet Page 23 of 49

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DINC	00	COMPL	ETED
		155200	B. WIN			04/20/	2012
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				UNIVERSITY BLVD		
UNIVERS	SITY NURSING CE	NTER			D, IN 46989		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	483.60(c) DRUG REGIMEI IRREGULAR, AG The drug regime reviewed at least pharmacist. The pharmacist to the attending pursing, and the upon. Based on interview, the faci Consultant Pharmacist of the dosages did maximum daily residents review medications. [Figure 12] Findings included the side of the dosage included the dosage	N REVIEW, REPORT CT ON In of each resident must be tonce a month by a licensed must report any irregularities physician, and the director of se reports must be acted view and record lity failed to ensure the armacist reviewed ers to ensure clear and to ensure d not exceed the dose for 4 of 10 wed for unnecessary Resident #'s 5, 39, 55, e: 5's clinical record was 18/12 at 9:21 a.m. The noses included, but d to, constipation, phy, debility, anxiety,	F04	TAG		nts /# th to ent e	
	docusate sodiu 100 mg capsulo mouth three tim	order. ad a current order for [a stool softener] at take one capsule by the solution once daily. initiated on 12/31/11.			indications are clear and maximum daily dosage is not exceeded. · DNS/ADNS inserviced the licensed nurses 05/10/12 on how to properly w and transcribe physicians orde and the licensed nurses will be educated on medications with	rite ers	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **765W11**

Facility ID: 000107

If continuation sheet

Page 24 of 49

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DUM DDIG	00	COMPLETED	
		155200	A. BUILDING		04/20/2012	
			B. WING	ET ADDRESS CITY STATE ZID CODE		
NAME OF I	PROVIDER OR SUPPLIE	R		ET ADDRESS, CITY, STATE, ZIP CODE		
LINID (ED)		NITED		S UNIVERSITY BLVD		
UNIVER	SITY NURSING CE	INTER	UPL	AND, IN 46989		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	COMPLET	·ION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
	The physician	had reviewed the		, ,	/hat	
	current orders	on 3/2/12.		measures will be put into pla		
				what systemic changes will l		
	During an inter	view with the Director		made to ensure that the defi	cient	
		4/20/12 at 10:05 a.m.,		practice does not recur:	awad	
				Physician orders will be revided daily by the DNS/Designee to		
		he order was clarified		ensure physician orders	`	
	· ·	read docusate sodium		directions and indications ar	e	
	· ·	ne capsule by mouth		clear and maximum daily do		
	three times a c	lay for constipation.		is not exceeded. · DNS/A	-	
	She indicated	the pharmacist had		inserviced the licensed nurs	es on	
	reviewed the re	esident's physician's		05/10/12 on how to properly		
		/12 and had made no		and transcribe physicians or		
		ons related to the		and the licensed nurses will		
	docusate sodiu			educated on medications wi		
	uocusate souit	illi older.		maximum daily dosage. · T		
	0 . 5			Pharmacy Consultant will re the physicians order during l		
	l '	39's clinical record was		monthly visit to ensure the		
		18/12 at 9:15 a.m. The		directions and indications ar	e	
	resident's diag	noses included, but		clear and the maximum daily	,	
	were not limite	d to, chronic kidney		dosage is not exceeded.		
	disease and co	ongestive heart failure.		Physicians order recaps will	be	
				reviewed monthly by 2 licens		
	The resident's	current physician's		nurses to ensure directions		
		gned by the physician		indications are clear and dos	_	
		ne physician's orders		do not exceed maximum dai	· I	
				dosage. How the corrective action(s) will be monitored to		
		needed order initiated		ensure the deficient practice		
	on 2/23/12, fo	-		not recur; i.e. what quality		
	_	en to aid respiration]		assurance program will be p	ut	
	0.083% 2.5/3r	ml vial: use one vial		into place: DNS/Design		
	per nebulizer t	hree times daily with		complete the Pharmacy Ser		
	ipratropium br	[a medication given to		CQI tool weekly for 4 weeks	then	
		0.02% use one vial		monthly x 3 months, then	_	
		ily with albuterol per		quarterly thereafter. Results		
		e order lacked an		the Pharmacy Service CQI t		
				will be discussed monthly at		
		hen the medication was		CQI meeting and the plan w	vhat	
	to be given.			adjusted accordingly. By v	viial	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DI 111	LDING	00	COMPL	ETED
		155200	B. WIN			04/20/	2012
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	R			UNIVERSITY BLVD		
I INII\/ER9	SITY NURSING CE	NITER			D, IN 46989		
ONIVEIX	SITT NONSING CL	INILIX		OI LAIN	D, IIV 40909		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	of Nursing on 4 she indicated the shortness of browning an interferor of Nursing on 4 she indicated the Pharmacy had change the alboro prn [as need to prn [as need to short to prn [as need to p	view with the Director 4/20/12 at 10:05 a.m., he Consultant a 1/18/12, request to uterol and ipratropium led].			date the systemic changes will completed: Systemic changes will be completed by 05/20/12.	l be	
	of Nursing on 4 she indicated the Pharmacist had resident's record/17/12 and no recommendation 3.) The clinical	d reviewed the rd on 3/19/12 and					
	but were not lir	Resident #55 included, mited to, hypertension, and change in mental ian's orders for					
	Resident #12 in limited to, the final a. Nitrostat (a	ncluded, but were not ollowing orders: medication given for fort) 0.4 milligrams					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **765W11**

Facility ID: 000107

If continuation sheet

Page 26 of 49

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DDIC	00	COMPL	ETED
		155200	A. BUII B. WIN			04/20/	/2012
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	₹			UNIVERSITY BLVD		
LINII\/EDG	SITY NURSING CE	NITED			D, IN 46989		
UNIVERS	SITT NURSING CE	NIER		UPLAIN	D, IN 40989		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	(mg) tablet						
	sublingually as	needed for chest pain					
	(original order	date 1/29/12)					
	`	,					
	The clinical rec	cord lacked any					
		directions from the					
		ed to how often this					
	medication cou	ilu be givell.					
		1. 8 6 10					
		cord indicated the					
	•	iewed the physician's					
		/12, 3/19/12, and					
	2/16/12, and no	o recommendations					
	were made to	clarify the above noted					
	incomplete phy	sician's orders.					
	' '						
	During an inter	view with the Director					
	_	1/19/12 at 1:45 p.m.,					
	_	mation was requested					
		ack of clarifications					
		e medication noted					
		g pharmacy reviews on					
	4/1 <i>/</i> /12, 3/19/1	2, and 2/16/12.					
		view with the Director					
	of Nursing on 4	1/20/12 at 10:30 a.m.,					
	she indicated t	here were no					
	recommendation	ons from the 4/17/12,					
		/16/12 pharmacy					
	reviews related	•					
	medication.						
	medicalion.						
	1 The dinica	I record for Desident					
	,	I record for Resident					
		ved on 4/17/12 at 3:13					
	p.m.						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **765W11**

Facility ID: 000107

If continuation sheet Page 27 of 49

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPLE		
AND PLAIN	OF CORRECTION	155200		LDING	00	04/20/2	
		.00200	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00	
NAME OF F	PROVIDER OR SUPPLIER				UNIVERSITY BLVD		
UNIVERS	SITY NURSING CE	NTER			D, IN 46989		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	ΓE	COMPLETION DATE
1710	REGUENTORT OR	ESC IDENTIFIEND IN ORDER TOOL		mo	<u> </u>		DATE
	but were not lin	Resident #12 included, nited to, leg cramps, associated with					
	pressure areas						
	Current physici	an's orders for ncluded, but were not					
		ollowing orders for					
	milligrams (mg)	ain medication) 325) tablet 2 tablets (650 urs routinely daily date 10/20/11)					
	contains Tylend	ain medication that ol) 5/325 mg 1 tablet ginal order date					
	mg tablet 2 tab	ain medication) 325 lets (650 mg) every 4 ed for pain (original /11)					
	contains Tylend	in medication that bl) 5/325 mg 1 tablet as needed for pain date 3/15/12)					
	contains Tylend	ain medication that bl) 5/325 mg 1 tablet as needed for pain date 3/15/12)					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **765W11**

Facility ID: 000107

If continuation sheet Page 28 of 49

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTII	PLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G	00	COMPL	
		155200	B. WING			04/20/	2012
NAME OF F	PROVIDER OR SUPPLIEF	₹			DDRESS, CITY, STATE, ZIP CODE		
UNIVERS	SITY NURSING CE	NTER			UNIVERSITY BLVD D, IN 46989		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	· ·	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)	PREI TA		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
	The 2010 Nursindicated the many report and lack related to the preport and lack related to the Torders following pharmacy revision of Nursing on 2 and 100 p	sing Drug Handbook naximum daily dose of not exceed 4000 mg in If April Narcotic sign out as needed Vicodin ove indicated the ation had been given as needed basis from th 4/6/12. It cord indicated the iewed the physician's /12 and no ons were made related exceeding maximum nded dose of Tylenol. It is with the Director 1/20/12 at 9:54 a.m., mation was requested on the vicodin general the vicoding genera					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **765W11**

Facility ID: 000107

If continuation sheet

Page 29 of 49

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/23/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 155200	A. BUII B. WIN	LDING	00	COMPL: 04/20/	ETED
	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE UNIVERSITY BLVD D, IN 46989		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ë	(X5) COMPLETION DATE
	policy, dated 7/CLINICAL CONPHARMACIST, Director of Nursell 18:40 a.m., includimited to, the form "Responsibilities limit to: Review of the opatient routinely	ISULTANT " provided by the sing on 4/20/12, at ded, but was not ollowing: s include but are not drug regimen of each y. Any irregularities the Medical Director, sing, and the					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **765W11**

Facility ID: 000107

If continuation sheet

Page 30 of 49

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DINC	00	COMPL	ETED
		155200	A. BUII B. WIN			04/20/	2012
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	L			UNIVERSITY BLVD		
UNIVERS	SITY NURSING CE	NTER			D, IN 46989		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0463 SS=D	483.70(f) RESIDENT CAL ROOMS/TOILET The nurses' statis receive resident communication is and toilet and bate and interview, it ensure each refunctioning call to summon state 40 residents obtained and interview and interview and interview and interview and interview and interview and independently. The clinical receive and independently. During an interview and independently.	L SYSTEM - T/BATH on must be equipped to calls through a system from resident rooms; thing facilities. rvation, record review, the facility failed to sident had a light in place in order ff assistance for 2 of oserved for a functional in. (Resident #58 and e: I record for Resident ved on 4/19/12 at 8:45 Ford indicated the ole to ambulate view on 4/16/12 at sident #58 indicated ve a call light in her icated she had not had is she was admitted in in indicated she did not int and would get up into the hall if she ining. She indicated been given a bell or	F04		F 463 Resident Call System Room/Toilet/Bath What corrective action(s) will be accomplished for those reside found to have been affected by the deficient practice: A notal light system will be installed on the locked unit on 05/20/12. The new call light system includes all resident rooms, bathrooms and shower room. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to affected by the deficient practice. All resident rooms, bathroom and shower rooms and common areas in the facility have been checked for functioning call lights. Any call lights not work properly have been repaired or replaced. What measures we be put into place or what system changes will be made to ensure that the deficient practice does not recur: All staff were inserviced by the Executive Director on 05/08/12 on the callight system, the procedure for when a call light is not working proper documentation, and the	nts y new ed . e be ce. ns on ing r vill emic re s	05/20/2012
	needed someth she had never	ning. She indicated			when a call light is not working	J ,	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **765W11**

Facility ID: 000107

If continuation sheet

Page 31 of 49

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		, DDIG	00	COMPL	ETED
		155200		LDING		04/20/	2012
			B. WIN		ADDRESS OFTW STATE ZID CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP CODE		
		NITED			UNIVERSITY BLVD		
UNIVER	SITY NURSING CE	NIER		UPLAN	D, IN 46989		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TF	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	the staff if need	ded.			deficiency. · DNS/ADNS	•	
					inserviced the licensed nurses	;	
	2 \ The clinica	I record for Resident			and CNA's on the call light		
	,				system, ensuring they are in		
		ved on 4/19/12 at 9:30			place and operational,		
	a.m.				documentation and the proced	lure	
					to follow if one is not working		
	The clinical rec	ord indicated Resident			properly. · All call lights in the	;	
	#60 had moved	d into her current room			facility will be checked on a weekly basis by the maintenar	200	
	on 3/2/12. The	e clinical record			man and documented on his		
	indicated the re	esident was able to			weekly Preventative Maintena	nce	
	ambulate indep				checklist. How the correcti		
		Deridently.			action(s) will be monitored to		
	Description and instant				ensure the deficient practice w	/ill	
	_	view on 4/16/12 at			not recur; i.e. what quality		
		sident #60 indicated			assurance program will be put		
	she did not hav	∕e a call light in her			into place: Executive		
	room. She ind	icated she would "yell"			Director/Designee will monitor		
	if she needed s	something. She			weekly Preventative Maintena	nce	
		nad never been given a			checklist for call lights. Any discrepancies found on the		
		er device to use to			checklist will be verified that the	10	
	summon the st				call light has been repaired an		
		all il lieeded.			documented on the CQI Resid		
					Call Light Monitoring tool. · A		
		observation on 4/16/12			items identified on the Resider		
	at 11:30 a.m., t	there was no call light			Call Light Monitoring tool will b	е	
	system presen	t in the room shared by			reviewed at the monthly CQI		
	Resident #58 a	and #60. The location			Meeting and the plan adjusted		
	on the wall for	the call light system			accordingly. By what date the	ne	
		te over the connection			systemic changes will be		
	•	light in the bathroom			completed: · Systemic		
		to be not working.			changes will be completed by 05/20/12.		
	was also noted	i to be not working.			00/20/12.		
	D	- i 1/40/40					
	_	view on 4/16/12 at					
	11:35 a.m., CN						
	Resident #58 a	and #60's room used to					
	be used as an	activity room and it did					
		light system in place.					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/23/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				00	(X3) DATE COMPL		
		155200	A. BUII B. WIN	LDING		04/20/	
			B. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			1564 S	UNIVERSITY BLVD		
UNIVERS	SITY NURSING CE	NTER		UPLANI	D, IN 46989		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
1110	TEGOETTON ON	250 132.1111 111.10 11.11 011.1111101.1)		0			5.112
	During an inter	view with the					
	_	ind Maintenance					
	Supervisor on 4	4/16/12 at 11:40 a.m.,					
		mation was requested					
		being not call light					
		e in the room shared by					
	Resident #58 a	INA #6U.					
	During an obse	ervation of Resident					
	#58 and #60's						
		ind Maintenance					
	Supervisor on 4	4/16/12 at 11:40 a.m.,					
	they indicated t	there was not a call					
	light system in	the resident's room					
		om call light was also					
	_	he administrator					
		dent #58 and #60					
		call light in their room					
		t know how this een missed. She					
	•	would be taken to					
	correct this pro						
	•	room would be given					
		til the call light was					
	replaced.	-					
	l '	the current facility					
	•	05, provided by the					
		sing on 4/20/12 at 8:45					
		Il Light Procedure" as not limited to, the					
	following:	as not minitou to, the					
	"Purpose: To a	allow resident to					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **765W11**

Facility ID: 000107

If continuation sheet

Page 33 of 49

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/23/2012 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER: 155200	A. BUILDING B. WING	00 	COMPLETED 04/20/2012
	ROVIDER OR SUPPLIER		1564 S	ADDRESS, CITY, STATE, ZIP CODE UNIVERSITY BLVD ID, IN 46989	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	CATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	request assista Equipment:	nce when needed.			
	1. Functioning	call light.			
	Procedure: 1. Place call lice	yht within reach of			
	resident at all ti				
	3.1-19(u)(1) 3.1-19(u)(2)				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **765W11**

Facility ID: 000107

If continuation sheet Page 34 of 49

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIII	LDING	00	COMPL	ETED
		155200	B. WIN			04/20/	2012
			J. 1111		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIER				UNIVERSITY BLVD		
UNIVER	SITY NURSING CE	NTER			ID, IN 46989		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
F0465 SS=C	ABLE ENVIRON The facility must sanitary, and cor residents, staff a	provide a safe, functional, mfortable environment for nd the public.	F10.4				05/00/0010
	Based on intervithe facility failed covers were in drains in the disensure the kitch missing tiles are there was no exitchen electric potential to affer receiving meals residents. Findings include During an obseton 4/19/12 at 1 Dietary Manage a floor tile missentrance to the There was an abuild up in the exitchen janitor of floor tile and basissing tile. The dirt collecting	view and observation, d to ensure drain place over 2 open shroom, failed to hen floor had no hed failed to ensure exposed gaps around a all outlet. This had the ect 55 residents is from the kitchen of 56 e: ervation of the kitchen 1:15 a.m., with the er present. There was ing in the right hand dry storage room. In accumulation of dirt missing area. uter corner next to the closest was missing a lase trim tile above the ne area had a build up in it.	F04	65	F 465 Safe/Functional/Sanitary/Comable Environment What corrective action(s) will be accomplished for those reside found to have been affected be the deficient practice: All items identified in the survey been repaired including the missing drain covers, missing floor tiles, the accumulation dibuilt up has been cleaned, trintiles were replaced and the unused electrical outlet was removed. How other resident having the potential to be affer by the same deficient practice be identified and what correctinaction(s) will be taken: All residents have the potential to affected by this deficient practice. All items identified in the sur have been repaired including missing drain covers, missing floor tiles, the accumulation dibuilt up has been cleaned, trintiles were replaced and the unused electrical outlet was removed. The Dietary Mana and staff will make observation daily of any necessary repairs. The needed repairs will be communicated to maintenance completing a work order requesting a work order reque	nts y nave rt n nts cted will ve be ice. vey the rt n ager ns .	05/20/2012
	There was an a build up in the in the left hand of kitchen janitor of floor tile and barnissing tile. The of dirt collecting Under the drying	uter corner next to the closest was missing a lase trim tile above the lare area had a build up g in it.			missing drain covers, missing floor tiles, the accumulation dibuilt up has been cleaned, trin tiles were replaced and the unused electrical outlet was removed. The Dietary Mana and staff will make observation daily of any necessary repairs The needed repairs will be communicated to maintenance	ager ns e by est. be	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **765W11**

Facility ID: 000107

If continuation sheet Page 35 of 49

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SU	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLET	TED
		155200	B. WIN			04/20/20	012
			D. WII		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	8					
		NTED			UNIVERSITY BLVD		
UNIVERS	SITY NURSING CE	NIER		UPLAN	D, IN 46989		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	TE (COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		DATE
	with no covers	over them.			maintenance man and		
					documented on his weekly		
	There were on a	electrical outlet in the			Preventative Maintenance		
					checklist. The checklist will be	e	
		back splash of the			used to identify any		
	three basin sin	k over the drying rack.			environmental or maintenance		
	The opening fo	r the outlet was too			issues in the dietary kitchen a		
		itlet box. There were			storage areas that need repair		
	_	around the electric			What measures will be put into		
	box.				place or what systemic chang		
	DOX.				will be made to ensure that the		
					deficient practice does not rec	ui.	
	~	view with the Dietary			 The Dietary Manager and staff will make observations d 	aily	
	Manager at the	time of the			of any necessary repairs. The	-	
	observation, sh	ne indicated she did not			needed repairs will be	1	
	know what the	plug-in was for and			communicated to maintenance	e hv	
	she had never				completing a work order reque	-	
	Sile flad flever	been asea.			The dietary department will		
	0.4.40/0				checked on a weekly basis by		
	3.1-19(f)				maintenance man and		
					documented on his weekly		
					Preventative Maintenance		
					checklist. The checklist will be	e	
					used to identify any		
					environmental or maintenance		
					issues in the dietary kitchen a		
					storage areas that need repair		
					The dietary floors will be deep		
					cleaned on a monthly basis by	, ine	
					facility's floor care man. Housekeeping/Laundry		
					Supervisor will be responsible	for	
					ensuring the deep cleaning		
					occurs on a monthly and		
					document the cleaning on the		
					monthly housekeeping schedu		
					How the corrective action(s)		
					be monitored to ensure the		
					deficient practice will not recu	r;	
					i.e. what quality assurance		
					program will be put into place:	:	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/23/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	00	COMPLETED				
		155200	B. WING		04/20/2012			
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1564 S UNIVERSITY BLVD					
UNIVERS	SITY NURSING CE	NTER	UPLAND, IN 46989					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
IAU	REGULATORT OR	ESC IDENTIFY THOUSAND THE PROPERTY OF THE PROP	IAU	Executive Director/Designe will be responsible for monitor the Preventative Maintenance checklist on a weekly basis for weeks, monthly for 3 months quarterly thereafter. Exect Director will monitor the housekeeping schedule to enthe dietary floor was deep cleaned monthly as required. Items identified on the Preventative Maintenance checklist tool or the will be discussed at the monthly CQI Meeting and the plan adjusted accordingly. By what date the systemic changes will be completed: Systemic changes will be completed by 05/20/12.	ering erring err			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **765W11**

Facility ID: 000107

If continuation sheet

Page 37 of 49

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 00 COMPLETED	
The Feat of Condition in Internation nomber.	
155200 A. BUILDING B. WING 04/20/2012	
STREET ADDRESS, CITY, STATE, ZIP CODE	
NAME OF PROVIDER OR SUPPLIER 1564 S UNIVERSITY BLVD	
UNIVERSITY NURSING CENTER UPLAND, IN 46989	
UNIVERSITY NURSING CENTER UPLAND, IN 40909	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)	
PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION CROSS-REFERENCED TO THE APPROPRIATE	ſ
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) DATE	
F0514 483.75(I)(1)	
SS=E RES	
RECORDS-COMPLETE/ACCURATE/ACCE	
SSIBLE	
The facility must maintain clinical records on	
each resident in accordance with accepted	
professional standards and practices that are	
complete; accurately documented; readily	
accessible; and systematically organized.	
The clinical record must contain sufficient	
information to identify the resident; a record	
of the resident's assessments; the plan of	
care and services provided; the results of any	
preadmission screening conducted by the	
State; and progress notes.	
Based on interview and record F0514 F 514 Resident Records – 05/20/2013	2
review, the facility failed to ensure Complete/Accurate/Accessible	
I I What corrective action(s) will be	
medication orders were complete and accomplished for those residents	
dosage information was clear to found to have been affected by	
ensure medications were given the deficient practice: Res. #	
correctly and did not exceed the 5, 39, 55, 12 medications have	
maximum daily dose, for 4 of 10 been reviewed and clarified with	
residents reviewed for unnecessary physician to ensure directions and indications are clear and	
medications. [Resident #'s 5, 39, 55, dosages do not exceed maximum	
daily dosage. How other	
residents having the potential to	
he affected by the same deficient	
Findings include: De allected by the same deficient practice will be identified and	
what corrective action(s) will be	
1.) Resident #5's clinical record was taken: All residents with	
reviewed on 4/18/12 at 9:21 a.m. The physicians orders for medications	
resident's diagnoses included, but have the potential to be affected.	
were not limited to constination	
Teviewed daily by the	
5 1 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5	
personality disorder. indications are clear and maximum daily dosage is not	
exceeded. · DNS/ADNS	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **765W11**

Facility ID: 000107

If continuation sheet Page 38 of 49

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:			00	COMPL	ETED
		155200		LDING		04/20/	2012
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	₹			UNIVERSITY BLVD		
LINII\/EDG	SITY NURSING CE	NITED			D, IN 46989		
	SITT NURSING CE	NIER		UFLAIN			
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		ATE.	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		_	TAG	DEFICIENCY)		DATE
		ad a current order for			inserviced the licensed nurses		
	docusate sodiu	ım [a stool softener]			05/10/12 on how to properly wand transcribe physicians order		
	100 mg capsul	e take one capsule by			and the licensed nurses will b		
	mouth three tin	nes daily once daily.			educated on medications with	-	
	This order was	initiated on 12/31/11.			maximum daily dosage. Wh		
	The physician	had reviewed the			measures will be put into plac	e or	
	current orders				what systemic changes will be		
		0.1 0, 2, 12.			made to ensure that the defici	ent	
	During an inter	view with the Director			practice does not recur:		
	_				Physician orders will be review daily by the DNS/Designee to	wea	
	_	1/20/12 at 10:05 a.m.,			ensure physician orders		
		he order was clarified			directions and indications are		
		read docusate sodium			clear and maximum daily dosa	age	
	•	ne capsule by mouth			is not exceeded. · DNS/AD	NS	
	three times a d	ay for constipation.			inserviced the licensed nurses		
					05/10/12 on how to properly w		
	2.) Resident#	39's clinical record was			and transcribe physicians order		
	reviewed on 4/	18/12 at 9:15 a.m. The			and the licensed nurses will be		
	resident's diag	noses included, but			educated on medications with maximum daily dosage. Th		
	_	d to, chronic kidney			Pharmacy Consultant will revi		
		ongestive heart failure.			the physicians order during he		
					monthly visit to ensure the		
	The resident's	current physician's			directions and indications are		
		gned by the physician			clear and the maximum daily		
	· · · · · · · · · · · · · · · · · · ·				dosage is not exceeded.	_	
		ne physician's orders			Physicians order recaps will b reviewed monthly by 2 license		
		needed order initiated			nurses to ensure directions ar		
	on 2/23/12, for	-			indications are clear and dosa		
	_	en to aid respiration]			do not exceed maximum daily	-	
		nl vial: use one vial			dosage. How the corrective	:	
	per nebulizer th	nree times daily with			action(s) will be monitored to		
	ipratropium br [a medication given to aid respiration] 0.02% use one vial				ensure the deficient practice v	vill	
					not recur; i.e. what quality		
		ly with albuterol per			assurance program will be puinto place: DNS/Designee		
		order lacked an			complete the Pharmacy Servi		
		nen the medication was			CQI tool weekly for 4 weeks, t		
	to be given.				monthly x 3 months, then		

ì ´		(X2) M	IULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155200	B. WIN	NG		04/20/	2012
NAME OF	PROVIDER OR SUPPLIEI	R			ADDRESS, CITY, STATE, ZIP CODE		
					UNIVERSITY BLVD		
UNIVER	SITY NURSING CE	NIER		UPLAN	D, IN 46989		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX	•	NCY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROIDED TO THE APPROIDED CROSS-REFERENCED TO THE APPROIDED TO			
IAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		IAG		\ f	DATE
TAG	During an inter of Nursing on a she indicated to shortness of bid During an inter of Nursing on a she indicated to recommendation change the albuform a routine order. 3.) The clinical #55 was review p.m. Diagnoses for but were not lind hyperlipidemia status. Current physical Resident #12 in the shortness of	view with the Director 4/20/12 at 10:20 a.m.,		TAG	quarterly thereafter. Results of the Pharmacy Service CQI too will be discussed monthly at the CQI meeting and the plan will adjusted accordingly. By who date the systemic changes will completed: Systemic changes will be completed by 05/20/12.	ol ne be nat	DATE
	angina discom (mg) tablet sublingually as (original order order lacked a	medication given for fort) 0.4 milligrams s needed for chest pain date 1/29/12) The ny information related ne medication could be					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **765W11**

Facility ID: 000107

If continuation sheet Page 40 of 49

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE COMPL		
		155200	A. BUI B. WIN	LDING IG		04/20/	
	PROVIDER OR SUPPLIES			1564 S	UNIVERSITY BLVD		
	SITY NURSING CE			<u> </u>	D, IN 46989		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	given.						
	of Nursing on 4 additional infor related to the complete for the During an inter of Nursing on 4 she indicated the	e Nitrostat medication. view with the Director 1/19/12 at 2:50 p.m., the order for the eation had not been					
	· '	I record for Resident ved on 4/17/12 at 3:13					
	but were not lir	Resident #12 included, nited to, leg cramps, associated with					
		ian's orders for ncluded, but were not ollowing orders for					
	milligrams (mg	ain medication) 325) tablet 2 tablets (650 ours routinely daily date 10/20/11)					
	, ,	ain medication that ol) 5/325 mg 1 tablet					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **765W11**

Facility ID: 000107

If continuation sheet

Page 41 of 49

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155200		A. BUILDING B. WING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED - 04/20/2012	
	PROVIDER OR SUPPLIE SITY NURSING CE		1564	ET ADDRESS, CITY, STATE, ZIP CO S UNIVERSITY BLVD AND, IN 46989)DE
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE COMPLETION
	twice a day (or 3/29/12)	iginal order date			
	mg tablet 2 tab	eain medication) 325 olets (650 mg) every 4 ed for pain (original 1/11)			
	d. Norco (a pain medication that contains Tylenol) 5/325 mg 1 tablet every 4 hours as needed for pain (original order date 3/15/12) e. Vicodin (a pain medication that contains Tylenol) 5/325 mg 1 tablet every 4 hours as needed for pain (original order date 3/15/12)				
	indicated the n	sing Drug Handbook naximum daily dose of not exceed 4000 mgs			
	sheets for the a order noted ab Vicodin medica	d April Narcotic sign out as needed Vicodin ove indicated the ation had been given as needed basis from h 4/6/12.			
	of Nursing on additional infor related to the	view with the Director 4/19/12 at 1:45 p.m., mation was requested Tylenol order not naximum daily dosage			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **765W11**

Facility ID: 000107

If continuation sheet

Page 42 of 49

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/23/2012 FORM APPROVED OMB NO. 0938-0391

	of Correction identification number: 155200	(X2) MULTIPLE CC A. BUILDING B. WING	00	COMPl - 04/20	
	PROVIDER OR SUPPLIER	1564 S	ADDRESS, CITY, STATE, ZIP CO UNIVERSITY BLVD D, IN 46989	DDE T	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	since the resident had multiple orders for medications containing Tylenol.				
	During an interview with the Director of Nursing on 4/19/12 at 2:50 p.m., she indicated she had no additional information to provide related to the incomplete Tylenol order. 3.1-50(a)(1) 3.1-50(a)(2)				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **765W11**

Facility ID: 000107

If continuation sheet

Page 43 of 49

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED			ETED	
		155200	B. WIN			04/20/	2012
	ROVIDER OR SUPPLIER		•	1564 S	ADDRESS, CITY, STATE, ZIP CODE UNIVERSITY BLVD D, IN 46989		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0516 SS=B	CLINICAL RECO A facility may no resident-identifia The facility may resident-identifia accordance with agent agrees not information exce itself is permitted. The facility must information again unauthorized use Based on obse and interview, t ensure resident secured from p 18 of 18 reside secured unit. Findings includ During an obse unit on 4/17/12 alarm sounded staff responded and indicated th and the alarm is possible fire as unit. The facility staf and the Medica	INFO, SAFEGUARD DRDS It release information that is ble to the public. release information that is ble to an agent only in a contract under which the to use or disclose the pt to the extent the facility it to do so. safeguard clinical record net loss, destruction, or e. rvation, record review, the facility failed to the clinical records were ossible fire damage for nts who reside on the	F05	16	F 516 Release Resident Info, Safeguard Clinical Records What corrective action(s) will be accomplished for those resider found to have been affected by the deficient practice: Residents' medical records will secured from possible fire damage per facility policy. Hother residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to affected by this deficient practic. Residents' medical records where secured from possible fire damage per facility policy. What measures will be put into place or what systemic change will be made to ensure that the deficient practice does not reconstructed the staff on 05/08/12 on the fire policy and procedure for security.	be nts y I be low be ce. will ones e ur: ced ee	05/20/2012
	Records to a lo	lunge located on the				-	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **765W11**

Facility ID: 000107

If continuation sheet

Page 44 of 49

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED
		155200	B. WIN			04/20/2012
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER	8			UNIVERSITY BLVD	
UNIVERS	SITY NURSING CE	NTFR			D, IN 46989	
					D, 114 10000	
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	ì ·	ICY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG		DATE
1		e fire doors. The fire			the residents' medical records during a fire drill or alarm.	
	department res	sponded to the fire			Charge Nurse/s/Designee will	he
	alarm.				responsible for removing the	
					medical records out of the fire	
	The resident's	clinical records were			zone during the fire drill or alar	m.
	located behind	the nursing station on			· The medical records will rem	
		els. The staff did not			out of the fire zone area until the	-
	remove the res	sident clinical records			all clear has been issued and t	
		red unit to the other			residents have been returned the area. • The removal of the	
	side of the fire				residents' medical records will	•
		d0010.			documented on fire drill form.	
	During an interview with the Administrator on 4/17/12 at 10:00				How the corrective action(s) w	ill
					be monitored to ensure the	
					deficient practice will not recur	,
		I information was			i.e. what quality assurance	
		arding the clinical			program will be put into place: DNS/Designee will be	
		ng taken from the unit			responsible for monitoring the	fire
	when it was ev	acuated.			drill forms to ensure that the	
					residents' records are removed	d
	During an inter	view with the			during a fire drill or fire alarm.	•
	Administrator of	on 4/17/12 at 10:20			DNS/Designee will be respons	
	a.m., she indica	ated the resident			for monitoring the fire drill form	
	clinical records	should have been			on a monthly basis for 3 month	
	moved off of th	e secured unit to the			and quarterly thereafter for six months. · Issues identified or	
	other side of th				the fire drill form will be discus	
		th facility policy.			at the monthly CQI Meeting ar	
					the plan adjusted accordingly.	
	Δ review of the	current, but undated,			By what date the systemic	
	facility policy, p				changes will be completed:	.
		-			Systemic changes will be	
		on 4/17/12 at 10:20			completed by 05/20/12.	
	a.m., titled "Procedure for Staff Response to Battery Powered Smoke					
		uded, but was not				
	limited to, the f	ollowing:				
	"4. Remove	charts and med				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **765W11**

Facility ID: 000107

If continuation sheet Page 45 of 49

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/23/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION OF CORRECTION 155200	(X2) MULTIPLE CO A. BUILDING B. WING	00	COMP	E SURVEY LETED 0/2012		
	PROVIDER OR SUPPLIER SITY NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1564 S UNIVERSITY BLVD UPLAND, IN 46989					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE		
	[medication] books past fire doors once all residents have been removed to safe areas" 3.1-50(e)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **765W11**

Facility ID: 000107

If continuation sheet

Page 46 of 49

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IC.	00	COMPL	ETED
		155200	B. WING	i.u		04/20/	2012
				TREET AL	DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				JNIVERSITY BLVD		
UNIVERS	SITY NURSING CE	NTER			DNIVERSITY BEVD D, IN 46989		
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PRE	FIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	TE .	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TA	AG	DEFICIENCY)		DATE
F0520 SS=E	QUARTERLY/PL						
	and assurance c	aintain a quality assessment ommittee consisting of the g services; a physician e facility; and at least 3 other facility's staff.					
	committee meets issues with respensive assessment and necessary; and continuous committee meets	essment and assurance is at least quarterly to identify ect to which quality assurance activities are develops and implements is of action to correct deficiencies.					
	disclosure of the except insofar as the compliance or requirements of	ecretary may not require records of such committee s such disclosure is related to of such committee with the this section.					
		ect quality deficiencies will					
	Based on intervals Assessment and Committee failed implement appropriate address the of 40 residents #60) observed light system and maintenance is the annual Recollicensure surveils.	ed to develop and ropriate plans of action lack of call lights for 2 (Resident #58 and for a functional call d environmental sues identified during certification and State	F0520		. F 520 QAA Committee – Members. Meet Quarterly/Plan What corrective action(s) will be accomplished for those resider found to have been affected by the deficient practice: The facility's QAA/CQI Committee on 05/16/12 to address the survey plan of correction including the call lights and Wander Guard alarms and to implement plans to correct any concerns noted from the CQI monitoring tools. How other residents having the potential of	nts / met	05/20/2012

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **765W11**

Facility ID: 000107

If continuation sheet

Page 47 of 49

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	ETED
		155200	B. WIN			04/20/	2012
			1	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	8			UNIVERSITY BLVD		
UNIVERS	SITY NURSING CE	NTER			D, IN 46989		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	OVIDER'S PLAN OF CORRECTION (X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	bathrooms obs	erved (Room numbers			be affected by the same deficient	ent	
	101, 103, 104,	106, 108, 109, 110,			practice will be identified and		
	111, 112, 205	and 207), potentially			what corrective action(s) will be		
		sidents residing in			taken: · All residents have th	е	
	_	f 56 residents in the			potential to be affected by this deficient practice. The facility	i's	
		. 00 residents in the			QAA/CQI Committee will meet		
	facility.				a monthly basis to monitor,	J.,	
		la.			evaluate, and provide follow-up	0	
	Findings includ	le:			action to continually improve a		
					provide excellence in care and		
	During an inter	view on 4/20/12 at			service. · CQI monitoring tool		
	8:25 a.m., the	Administrator indicated			formulated by the survey will b	е	
	the facility qual	ity assurance program			reviewed and plans will be		
	had not identifi				implemented to correct any concerns from the CQI monitor	rina	
					tools. What measures will be	•	
	The lack of a c	all light present in the			into place or what systemic	put	
		by Resident #58 and			changes will be made to ensur	e	
	•	by Nesident #30 and			that the deficient practice does		
	#60,				not recur: · The facility's		
		nt concerns in the			QAA/CQI Committee will meet	on	
		ooms 101, 103, 104,			a monthly basis to monitor,		
		110,111, 112, 205			evaluate, and provide follow-up		
	and 207, poten	itially affecting 22			action to continually improve a provide excellence in care and		
	residents resid	ing in those rooms.			service. The process includes		
	The Administra	ntor indicated a plan			departments and key facility	J	
	had not been p	out in place to address			practices. · CQI monitoring to	ols	
	'	issues prior to her first			formulated by the survey will b		
		surance) meeting held			reviewed and plans will be		
	· · · ·	er her placement as an			implemented to correct any		
		strator in the facility on			concerns from the CQI monitor	ring	
	4/1/12.	strator in the facility on			tools. How the corrective		
	 4 / /				action(s) will be monitored to ensure the deficient practice w	ill	
					not recur; i.e. what quality		
	3.1-52(b)(2)				assurance program will be put		
					into place: · Monitoring tools		
					formulated by the survey plan		
					correction will also be discusse	ed	
					at the monthly CQI meeting. fo	r 3	
			1				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **765W11**

Facility ID: 000107

If continuation sheet Page 48 of 49

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/23/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155200			A. BUILDING 00		COMPLETED 04/20/2012	
NAME OF P	PROVIDER OR SUPPLIE		B. WING STREET A	ADDRESS, CITY, STATE, ZIP CODE	04/20	12012
UNIVERSITY NURSING CENTER			1564 S UNIVERSITY BLVD UPLAND, IN 46989			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	N BE PRIATE	(X5) COMPLETION DATE
	-			months and then quarterly thereafter for six months. The plans will be adjusted as not to ensure all issues are reviand corrected. By what does systemic changes will be completed: Systemic changes will be completed by 05/20/1.	The seded ewed te the	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **765W11**

Facility ID: 000107

If continuation sheet

Page 49 of 49